Medicaid HMO and Fee-for-Service Comparison Strategy: Methodological Issues

Final Report

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Suite 500
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Methodological Issues
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Rachel Block, Director, Data Systems Group
HCFA, Baltimore MD

Timothy Clifford MD, Medical Director
Bureau of Medical Services, Augusta ME

Tom Fanning, Director, Management Reports & Research
Office of Medicaid Management, Albany NY

Glenn Jennings, Consultant
TennCare, Nashville TN

Kenneth Lampert, President and Medical Director
Community Premiere Plus, New York NY

Garland Land, Division Director, Department of Health
Division of Health Resources, Jefferson City MO

Patricia McTaggart, Director, Quality and Performance Management Groups
HCFA, Baltimore MD

Lee Partridge, Director, Health Policy Unit
American Public Welfare Association, Washington DC

Margaret Schmid, Manager, State and Federal Projects
NCQA, Washington DC

Linda Schofield, CEO
Kaiser Health Plan, Amherst MA

Donald Umlah, Director of Maternal and Child Health Department
Arizona Physicians IPA, Inc., Phoenix AZ

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El Barron, **Alabama Medicaid Agency**, Peggy Bartels, **Bureau of Health Care Financing (WI)**, Mary Jo Chevuront, **First Mental Health (TN)**, Donna Cross, **HCFA (GA)**, Sheila Denny, **Alabama Medicaid Agency**, Ron Doran, **New York State Department of Health**, Patsy Evans, **HCFA (GA)**, Bill Gandy, **First Mental Health**, Harry Gill, MD, PhD, **Department of Human Services (IA)**, Jim Goodpasture, **Florida Agency for Health Care Administration**, Mary Hogan, **First Mental Health**, Denise Ingram, MD, Cathy Kasriel, **HCFA (GA)**, Charles Kight, **Florida Agency for Health Care Administration**, Coleen Kivlahan, MD, **University of Missouri**, Neda Lewis, **First Mental Health (TN)**, Michael McDaniel, **HCFA (GA)**, Debra McLean, **Alabama Medicaid Agency**, Patrick Roohan, **New York State Department of Health**, Dick Shoemaker, **Office of Medical Assistance Programs (OR)**, Tracy Tang, **Florida Agency for Health Care Administration**, Susan Welch, **Office of Health Services Administration (NJ)**

Jessica Briefer French
Assistant Vice President for State and Federal Projects
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EXECUTIVE SUMMARY

Medicaid programs across the country increasingly use managed care organizations (MCOs) to deliver care to beneficiaries. At the same time, they continue to serve a significant proportion of beneficiaries through Primary Care Case Management (PCCM) programs, and still use fee-for-service (FFS) to deliver care to some categories of beneficiaries. As a result, questions of the relative quality and effectiveness of Medicaid MCOs, PCCM, and FFS programs are salient.

With grants from the Center for Health Care Strategies and the David and Lucile Packard Foundation, NCQA, APWA, and HCFA convened a Work Group to help develop a methodology to apply HEDIS® to compare the quality and effectiveness of these programs. This paper reflects the Work Group's thinking about how to address methodological issues related to applying HEDIS measures in non-managed care settings in Medicaid programs, including PCCM and FFS.

The Work Group believes that most HEDIS measures can be applied to PCCM and FFS programs as well as to MCOs if:

- the accountable entity is identified;
- the benefits which must be delivered are specified; and
- the population to which such benefits must be delivered is identified.

The paper identifies the assumptions upon which comparative applications of HEDIS rest: common benefit sets, uniform eligibility categories, consistency in voluntary or mandatory enrollment, and consistency in the geographic concentration of the delivery systems.

The Work Group identified numerous comparisons which might be performed using HEDIS for the FFS and PCCM populations. These include:

- FFS, PCCM, and MCO performance within a state;
- FFS, PCCM, and MCO performance compared to benchmarks, standards, or goals;
- performance of FFS, PCCM, and MCO programs over time;
- relative performance of FFS to MCO and PCCM programs across states;
- comparison of plan performance for special needs populations;
- comparison of Medicaid program-level performance (aggregated across delivery systems) across states; and
- comparison of FFS, PCCM, and MCO performance across regions within a state.

The Work Group reviewed recent approaches to comparing MCO and FFS performance, and developed a recommended approach to calculating HEDIS measures for MCO and FFS delivery systems. The paper includes a table of HEDIS 3.0/1998 measures that are theoretically applicable to the Medicaid population, and lists issues that relate to the use of those measures for the FFS and PCCM programs.

For PCCM programs, the accountable entity would be the primary care provider; the benefits to be delivered would include not only primary care benefits, but also those benefits delivered through the referrals which the primary care provider controls; the population would be those persons assigned to the primary care provider over the period of time defined by the measurement specification. For FFS programs, the accountable entity would be the Medicaid agency; the benefits to be delivered would be the benefits covered by the program; and the population would be those persons eligible for Medicaid over the period of time defined by the measurement specification. This assessment is summarized in the table below:

Actual & Theoretical HEDIS Uses

Type:	Accountable entity:	Accountable for:	Delivered to:
MCO *current use*	MCO	Delivery of contractually specified services	Enrolled population meeting measurement criteria
PCCM *theoretical use*	Primary Care Case Manager	Delivery of primary care and case-managed services	Eligible persons with defined period of assignment
FFS *theoretical use*	Delivery system payer (Medicaid)	Delivery of all Medicaid covered services	All eligible members with defined length of Medicaid eligibility

The Work Group identified methodological issues and practical problems associated with applying HEDIS measures to PCCM and FFS programs. These include continuous enrollment requirements which exclude significant parts of the relevant population; challenges in capturing complete data for measures with look-back periods that exceed the continuous enrollment periods; data availability, reliability, and validity problems in all settings, which may vary by program and state; loss of detail due to the use of global or package codes for paying claims; changes in program structure and enrollment patterns over time; and the potential for differences in third party coverage rates for different population subgroups.

The Work Group discussed the potential of using alternative data sources such as vital statistics information for selected HEDIS measures. In addition, the Work Group discussed, but rejected, the use of alternative specifications for calculating selected measures. Finally, the Work Group identified issues for future research, including using measures of health status for risk adjustment; analyzing the presence and effects of selection bias on program performance, including the effects of voluntary MCO selection compared to default assignment.

This paper represents the beginning of a dialogue about how to apply HEDIS measures to the PCCM and FFS populations. The Work Group anticipates that states will pilot test the methods outlined either independently or preferably, using a common set of measures. Such a pilot test could be used to further refine the methodology described and increase the depth of information available about the implementation issues.

I. BACKGROUND AND RATIONALE

The Health Care Financing Administration (HCFA)'s Office of Managed Care reported in January 1997 that, as of June 30, 1996, nearly eight million Medicaid beneficiaries were receiving their care through a managed care organization (not including primary care case management programs). Although the June 30, 1997 data are not yet available, we expect the new figure will be nearly nine million, as several states, such as Missouri and Texas, have implemented managed care expansions during the past year. Because of the rapid growth in the use of managed care by Medicaid programs and the still significant presence of fee-for-service (FFS) care, questions of the relative quality and effectiveness of these programs continue to be salient.

Measures of quality and health plan performance have developed in the managed care setting (rather than other settings) because of several key characteristics of managed care. First, managed care organizations (MCOs) serve a defined population. The population is enrolled in the MCO and the MCO receives premiums in advance for all enrollees. Second, managed care organizations are comprised of defined delivery systems. The MCO contracts with physicians, hospitals and other providers of clinical services, and with minor exceptions, enrollees are required to receive covered services through this defined delivery system. These two characteristics, in combination with a managed care organization's information systems capability, enable the MCO to actively manage care. HEDIS® is the first and only measurement set to standardize the measurement of managed care performance. HEDIS is a set of measures with specific definitions and detailed instructions for their calculation. Its purpose is to enable managed care organizations to measure and report the same indicators in a standard way, allowing plan-to-plan comparison.

Numerous state Medicaid officials and representatives from the American Public Welfare Association (APWA) have sought guidance on how to use HEDIS data to compare managed care performance to that of FFS Medicaid programs. In a survey of state Medicaid officials, conducted jointly by NCQA and APWA, eight states volunteered that they intend to use HEDIS data to compare aggregate managed care performance with the quality of care provided under FFS. As a result, NCQA undertook to develop an approach to applying HEDIS measures in non-managed care settings, including Primary Care Case Management (PCCM) and FFS.

With grants from the Center for Health Care Strategies and the David and Lucile Packard Foundation, NCQA, APWA and HCFA convened a work group (Work Group) to help develop a methodology. Members of the Work Group reviewed drafts of this paper and provided comments. The Work Group met in September and December 1997 to review the current drafts and reach consensus on a number of issues that members had raised during earlier reviews. This paper reflects NCQA's, APWA's and the Work Group's resulting thinking about how to address methodological issues related to applying HEDIS measures in non-managed care settings, including PCCM and FFS.

II. INTRODUCTION

The purpose of this document is to begin a dialogue about, and to initiate some controlled experimentation with, the application of HEDIS measures to the PCCM and FFS populations. Once finalized, the Work Group anticipates the document will be published and widely distributed to Medicaid Directors and policy analysts. The Work Group anticipates that states will pilot test the methods outlined using one or two common HEDIS measures. Such a pilot test could be used to further refine the methodology described. Additionally, the pilot test could identify new areas requiring explanation or add to the depth of the information available about the implementation issues. NCQA is enthusiastic about working with the states on such a pilot test. The grants covering the development of this methodology are insufficient to support such a pilot; however we believe NCQA, HCFA, APWA and the National Association of State Medicaid Directors could readily obtain funding for this effort.

This paper addresses methodological approaches and problems relevant to conducting selected analyses of Medicaid FFS, PCCM and managed care organization performance. In order to keep the discussion focused, the approaches described depend on certain assumptions. These assumptions include:

- the use of common benefit packages. To avoid biasing effects, the analysis must ensure that the data being reviewed concern common benefit sets. Further, the effects of non-standard benefits must be considered. For example, a population with a drug benefit can be expected to have health care consumption patterns different from that of a population without such a benefit. Even if the drug benefit itself is removed from the comparative analysis, the impact of that benefit may bias the analysis if not overtly recognized and addressed.

- uniform eligibility categories in those programs or states that are the subjects of comparison. For example, populations such as special needs children or the medically needy must be excluded from comparisons of the AFDC population, to ensure that income, demographic (age, gender) and health status characteristics do not bias the results. Programs which enroll beneficiaries above the federal poverty level may have populations which differ in key income or demographic characteristics. Such differences should be addressed in any analysis.

- consistency in voluntary or mandatory enrollment in MCOs. Programs with voluntary MCO enrollment may attract beneficiaries with income, demographic, health status characteristics, or care-seeking behavior that differ from beneficiaries enrolled in mandatory managed care programs. These differences could affect measurement results.

- consistency in the geographic concentration of health care delivery systems. Managed care organizations located in rural as compared with urban areas, for example, may have less ability to influence the practice patterns of their participating providers; likewise, FFS practice patterns in rural areas may differ from those in urban areas.

To the extent that these assumptions are not borne out, adjustments can be made to the analyses presented; however these adjustments are beyond the scope of this paper.

The Work Group identified a number of analyses or comparisons that they wanted to be able to perform using HEDIS for the FFS and PCCM populations. This paper focuses on these selected analyses. The Work Group identified additional analyses that were of interest, but of lower priority. These analyses would be suitable for future research, and are identified at the end of this paper.

Finally, the Work Group discussed a number of methodological problem areas that require further work or explanation. Some members of the Work Group expressed interest in developing a detailed educational manual for states to use in implementing the comparative methods described in this paper. This manual would provide contextual information and explanations about the various cautions and caveats that states should heed in comparing performance across systems of care or over time. While this paper does not undertake this detailed explanation, some of the issues that could be included in such a manual are identified and briefly described.

III. ESSENTIAL COMPARISONS

The Work Group identified the following comparisons or analyses as particularly salient. Each is briefly described below. The methodological issues presented in this report are relevant to these analyses in particular, although they may have broader applicability as well.

FFS Program Compared to Aggregate MCO and PCCM Program Performance Within a State

State Medicaid Directors who are responsible for providing care through these three programs have expressed interest in being able to compare performance at the program level. This analytical approach would require aggregating results for the MCO program to compare to the PCCM and FFS programs. The state would have to consider whether voluntary or mandatory MCO enrollment, MCO or provider assignment protocols, differing length of Medicaid eligibility or other factors might be reflected in apparent performance differences.

Performance of FFS, MCO and PCCM Programs Compared to Benchmarks, Standards, or Goals

In addition to comparing the performance of different delivery systems to each other, Medicaid Directors need to compare the performance of each system to benchmarks, standards, or goals. Benchmarks are normative measures reflecting current practice. They may be national, regional, or state averages. Standards of care reflect clinical evaluations as to desirable levels or types of service or treatment. They may also be defined in terms of best practices. Standards, too, may be national, regional, or state-defined and may differ. Performance may also be evaluated against goals such as *Healthy People 2000,* or the goals which some states have established. Such goals identify desired outcomes, such as levels of childhood immunization or breast cancer screening.

Each of these evaluative tools provides a somewhat different analytical focus which will yield different results. All offer an evaluative framework broader than comparison of one program to another in a state, thus providing Medicaid Directors with an expanded view of plan performance.

Performance of FFS, PCCM and MCO Programs Over Time

Beyond comparing the performance of different programs, Medicaid Directors have an interest in tracking performance of programs over time. States continually need to answer the question of whether Medicaid beneficiaries are better or worse-off than in the past. In performing analyses of performance over time, states must take into account significant changes in program structure. For example, new mandatory MCO enrollment, significant benefit changes or a major shift in eligibility rules could result in apparent changes in program performance that really reflect program design changes. Establishing an initial baseline measure of program performance against which to track performance over time is a key component of this analysis.

Relative Performance of FFS to MCO and PCCM Programs Across States

The Work Group anticipates that Medicaid directors will find performance differences in the different delivery systems operating within a state's Medicaid program. National data about the consistency and magnitude of those performance differences would help inform Medicaid policy

and program design. Those evaluating the relative performance of different delivery systems across states will have to account for differences in benefits, program design, enrollment patterns and eligibility requirements as described in the Introduction.

Plan Performance for Different Sub-populations (special needs) to Each Other and to Overall Population

The Work Group believes that some HEDIS measures, despite risk adjustment issues, might be used to compare the performance of the Medicaid program in serving different eligibility groups. Such analyses could be performed both within delivery systems (MCO, FFS, PCCM) and across delivery systems. For example, it may be useful to evaluate differences in satisfaction with care or rates of service provision among the Aid to Families with Dependent Children (AFDC) and the Supplement Security Income (SSI) populations. It may also be useful to evaluate differences in health plan performance for identifiable population sub-groups such as persons with disabilities, children in foster care, or HIV-infected pregnant women, although limits to system capability to identify and track such sub-groups restrict the feasibility of such analyses. An additional sub-group of interest is Medicaid beneficiaries who have a stable relationship with a primary care provider in the FFS or PCCM delivery systems. Comparison of their results on selected measures with the results for beneficiaries enrolled in MCOs would yield important information on the relative performance of the delivery systems. These areas of inquiry require further development.

Selected Measures Across States

There are a number of HEDIS measures that reflect the fundamental performance of managed care organizations. These measures may potentially capture the performance of the FFS and PCCM delivery systems as well. Childhood Immunization Status, Cervical Cancer Screening, Prenatal Care in the First Trimester and Well Child Visits, among other measures, provide important information about a delivery system's performance on key, agreed-upon standards of preventive care. Beta Blocker Treatment After a Heart Attack and Eye Exams for People with Diabetes are measures which provide important information about a delivery system's delivery of service to persons with acute or chronic illness. When HEDIS measures are properly collected in accordance with specifications, the reported measures can be aggregated across delivery systems in a weighted manner to yield performance indicators for the state's Medicaid program as an entity.

The Work Group acknowledges the problems that continuous enrollment requirements and low enrollments can cause in measuring and comparing performance across delivery systems. The Work Group believes that the value of objective, comparable measures of performance merits continued efforts to surmount these problems. State-to-state comparison of performance on selected measures provides states with a yardstick by which to assess their own program performance. It also provides policy makers with important information about the variability of performance. Finally, such comparison potentially could enable policy makers to identify those program features that are most closely associated with better performance.

Performance of the FFS, PCCM and MCO programs Across Regions Within a State

Health care is delivered locally in every community. Significant geographic variation exists in patterns of care. In many states, Medicaid contracts with providers and MCOs at the county or region level. There may be vast differences in delivery systems, access and quality between rural and urban areas. State Medicaid directors can use identified differences in performance across regions to target interventions, and to better understand state-wide performance. The Work Group recognizes that there are significant practical obstacles to capturing and analyzing HEDIS measures on a region-specific basis, including small numbers and, for some measures, the significant burden associated with medical record sampling for each HEDIS report required.

IV. APPLYING HEDIS MEASURES TO PCCM AND FFS

The HEDIS 3.0 measurement set consists of 51 reporting set measures applicable to the Medicaid population. These measures are organized into seven categories, or "domains." For each measure, HEDIS specifies the allowable data sources and the methods that a health plan may use to compute the measure. Many measures, including most of the measures in the Use of Services and Cost of Care domains, must be calculated using a plan's administrative data--its membership, claims and encounter data. Other measures, including many in the Effectiveness of Care domain and some in the Use of Services and Access/Availability of Care domains, allow a plan to use a combination of administrative data and medical records (the hybrid method). These different methods and allowable data sources carry with them differing degrees of difficulty and labor-intensity. Most plans find that administrative data are most efficient to use. However, for many measures that require clinical or service-level detail, administrative data are incomplete, and plans choose to supplement the data by using a sample of medical records. Finally, plans must contract for a survey of their members to calculate some measures.

The HEDIS measures that are most difficult to apply to the Medicaid population are those that have a continuous enrollment requirement for the denominator population. For these measures, the rationale for the continuous enrollment requirement is that the managed care plans need to be responsible for an individual for a minimum amount of time before they can be held accountable for delivering some, particularly preventive, services. The Medicaid HEDIS work group, the group that adapted the HEDIS measures to the Medicaid population, agreed this period of time generally should be one year. The one-year continuous enrollment period has been carried forward into HEDIS 3.0 and HEDIS 3.0/1998. Other continuous enrollment requirements are appropriate for specific measures. In addition, several HEDIS measures involve look-back periods of longer duration than the period of continuous enrollment, e.g. the number of women who had a Pap test over the last three years and the number of two-year-olds who are fully immunized.

Because of the high turnover in the Medicaid population, the continuous enrollment requirements are more difficult to apply to the Medicaid population than to the commercially insured population. This difficulty applies equally to performance measurement in the MCO, PCCM, and FFS environments. However, it reflects a weakness of the insurance system, rather than of the measurement of performance. If eligibility rules and procedures make it impossible for a Medicaid beneficiary to stay continuously enrolled in a MCO, a PCCM, or the FFS system, then there is little opportunity for the MCO or provider to truly manage care. This failure of the insurance system to support enrollment through time is not sufficient reason to abandon the measurement of the effectiveness of managed care. Rather, it argues for systemic change in the insurance mechanism to provide Medicaid beneficiaries the opportunity to receive health care over time.

Recent Approaches to Comparing MCO and FFS Performance

Recent analyses comparing the performance of managed care plans with that of FFS providers have taken two different approaches. Some data about immunization rates, for example, simply presents percentages of fully immunized children two and over by type of insurance coverage--

FFS or managed care at a point in time. This approach does not factor in the amount of time the child was covered through a managed care organization, and so may not accurately reflect the performance of the two types of health care delivery systems.

The state of Wisconsin used a second approach. Wisconsin has put out an extensive set of statistics for at least two years comparing its Medicaid managed care and FFS programs. For all performance measures, Wisconsin reports rates for the provision of specific services per eligible and rates per eligible-years. The latter statistics control across health plans and programs for variations in the amount of time eligibles may be enrolled in the plan. This seems necessary, at a minimum. This approach still does not address the issue that continuous enrollment periods are designed to address--that health plans need a minimum period of time before they should be held accountable for providing services to an enrollee.

Further, this approach makes the interpretation of measures more difficult. HEDIS measures that use continuous enrollment periods are easy to interpret, because the measures relate to standards of care that are at least theoretically applicable. When the continuous enrollment period is eliminated, the measure can still be used to assess the relative performance of two systems (managed care and FFS), but it cannot easily be used to assess performance against a standard of care.

In order to adopt the Wisconsin approach, a Medicaid agency using HEDIS would have to ask its managed care plans to compute some measures twice--as specified in HEDIS and as rates per member years, ignoring continuous enrollment requirements. (HEDIS uses 1,000 member months as the denominator for some utilization measures.)

Recommended Approach to Calculating HEDIS Measures for MCO and FFS Delivery Systems

In order to reflect the intention behind the HEDIS measures, the Work Group agreed that the HEDIS measures required by a state be calculated by the health plans as specified in the current version of HEDIS (HEDIS 3.0/1998 is the current version as of this writing). The state would then use its eligibility and claims data, and possibly medical records, to calculate comparable rates for the FFS and any PCCM programs. For the FFS program, the state would interpret continuous enrollment to mean that, for measures with continuous enrollment requirements, individuals in the denominator had Medicaid coverage for the period of time specified as the continuous enrollment period. For the PCCM program, the state could interpret the continuous enrollment requirement to mean a beneficiary was enrolled with a particular primary care provider for the specified continuous enrollment period, or the state could treat the PCCM program in the same manner as the FFS program. Utilization data for both FFS and managed care would use 1,000 member months as the denominator, where specified in HEDIS.

By using this methodology, the state would measure the performance of the managed care plans for individuals enrolled in the plans for the continuous enrollment period, as intended and specified in HEDIS. While there is no comparable enrollment and responsibility by individual providers in the FFS system, many states view the FFS system as the state's health care plan. As such, the state assumes responsibility for the quality of care provided to its FFS population.

Legislation on the books requiring states to perform drug utilization review and mandating that states exercise responsibility for ensuring that children receive appropriate preventive health care exemplify this view of the state's responsibility.

Application of this approach to the FFS system as an entity is relatively new, but perhaps merited. Numerous states have implemented various forms of care management, including establishing drug formularies; requiring certain types of utilization review or precertification and carving out certain benefits and negotiating case or capitation rates for the provision of selected services. In these ways, the state acts as more than simply the payer. Rather, the state takes on some care management functions and with them, the responsibility and accountability for quality.

There are practical implications that flow from this view of the FFS program. If the state, or some identifiable agent of the state is indeed responsible for quality, the state would have to serve a number of new functions. For example, in order to manage care in a manner comparable to the best MCOs, the state would have to conduct outreach and possibly surveys to its FFS program eligibles to determine their status with respect to key preventive services; the state would then have to encourage individuals who are behind in preventive care to obtain needed services and the state would need the ability to track services delivered and follow up where they were still delinquent. While not all MCOs perform these functions, they at least theoretically have the capacity to perform them. If the state views itself as care manager with responsibility and accountability for quality, by extension it would have to have some vehicle for carrying out that responsibility.

The PCCM program could be treated either as a managed care program (with the continuous enrollment criteria applied to selection of a primary care provider) or as a FFS program. If the performance of the managed care program is inferior to the performance of the FFS or PCCM programs when using this methodology a state should have serious concerns about the performance of the managed care plans. This methodology gives managed care plans the advantage of measuring their performance in certain areas only when the plan has had a meaningful opportunity to improve the health of enrolled beneficiaries. If the managed care plans cannot at least match the performance of the FFS and PCCM programs under these circumstances, then a state may have reason to question the value of its expenditures for managed care. At a minimum, the state will need to take action to improve the performance of its managed care program.

Measures Applicable to the FFS System

All of the effectiveness of care, access and utilization measures are *theoretically* appropriate for comparing managed care and FFS. There has been some debate about the applicability of measures with look-back periods that are longer than the continuous enrollment requirement to the FFS system. Some members of the Work Group argued that these measures cannot be realistically calculated for the FFS population because of the difficulties in obtaining data about services rendered prior to Medicaid eligibility. Others argued that the challenges in obtaining data about care rendered prior to the initiation of enrollment are universal, and that the FFS, PCCM and managed care programs should be held to the same standards, particularly given the view of the FFS program as the state's health plan. The Work Group agreed upon this latter argument.

As a result, measures with look-back periods that are longer than the required continuous enrollment period are included as relevant and applicable to the FFS population.

Again, this argument has practical implications for the role of the state. The problem of obtaining data about services rendered prior to Medicaid eligibility is similar in nature to that faced by MCOs. However, the magnitude of the data problem may differ. This, again is an issue that merits empirical evaluation.

The cervical cancer screening measure assesses the percentage of women enrolled for one year who received a Pap test during the last three years, and the childhood immunization measure reflects the percentage of children enrolled for the one year preceding their second birthdays who received all the immunizations required from birth to age two. In addition, the adolescent immunization status measure assesses the percentage of children enrolled for one year prior to their thirteenth birthday who received a MMR vaccine in the preceding nine years. These measures are difficult for HMOs with many recent members and relatively small provider networks because they require access to information about medical care provided prior to HMO membership. For the same reason, they are difficult to calculate in the FFS setting. These measures capture two distinct aspects of performance. First, they measure service provided (i.e. number of immunizations or pap smears provided). Second, they capture performance related to management of care (through capture of information about services provided *prior* to enrollment - or to Medicaid eligibility). The Work Group argued that this second component of the measure is relevant in the FFS setting, because the state is accountable for the quality of care delivered in this setting. The Work Group expects these measures to favor managed care plans because they are inherently better able to manage care and assure quality. This expected difference in performance is a compelling reason to measure managed care organizations, PCCM programs and FFS programs according to a single standard.

States will need to go through the HEDIS measures and identify specific measures that require data elements that are not available through their information systems. There will undoubtedly be a number of data elements that are not available from claims and eligibility data. Once a state has identified these measures and data elements and selected a set of measures that are feasible for collection in the PCCM and FFS settings, it could implement a sampling and medical record review strategy. The practical considerations of conducting medical record sampling for the FFS population are significant. Empirical data from multiple states attempting this strategy will demonstrate the feasibility of this approach.

The following table takes HEDIS 3.0/1998 measures theoretically applicable to the Medicaid population and lists any issues that relate to the use of those measures for the FFS and PCCM programs. An "X" in the FFS and the PCCM columns indicates that the measure is feasible for measuring the quality of care provided by those delivery systems. The issues listed in the last column are those that might hamper data collection or that have special requirements.

HEDIS Domain: Effectiveness of Care

HEDIS Measure	*FFS*	*PCCM*	*Issues*
Childhood Immunization Status	x	x	Continuous enrollment Look-back period: two years
Adolescent Immunization Status	x	x	Continuous enrollment Look-back period: up to nine years
Advising Smokers to Quit	x	x	Survey measure
Breast Cancer Screening	x	x	Continuous enrollment
Cervical Cancer Screening	x	x	Continuous enrollment Look-back period: three years
Prenatal Care in the First Trimester	x	x	Continuous enrollment: 280 days prior to delivery Similar to health plans, a state may find it difficult to identify live births. The HEDIS specifications suggest several methods that a state may wish to review. This measure requires identifying women through hospital claims and matching them to outpatient claims.
Low Birth-Weight Babies	x	x	Moratorium for reporting year 1997. Risk adjustment will be an issue.
Check-Ups After Delivery	x	x	Continuous enrollment: enrolled 56 days after a live birth Similar to health plans, a state may find it difficult to identify live births. The HEDIS specifications suggest several methods that a state may wish to review. This measure requires identifying women through hospital claims and matching them to outpatient claims.
Beta Blocker Treatment After a Heart Attack	x	x	This measure requires identification of the eligible population by diagnosis. Capturing prescribed (not dispensed) medication will be difficult.
Eye Exams for People with Diabetes	x	x	This measure requires identification of the eligible population by diagnosis.

HEDIS Domain: Access to Care

HEDIS Measure	*FFS*	*PCCM*	*Issues*
Adults' Access to Preventive/Ambulatory Health Services	x	x	Continuous enrollment: one year.
Children's Access to Primary Care Providers	x	x	Continuous enrollment: two years State will need to define primary care providers.
Availability of Dentists	*	x	Some states have Dental Care Case Managers and should be able to compute this measure. *It is not feasible to apply the measure specifications in the FFS environment. However, alternative methods of getting information on whether dentists are available to Medicaid beneficiaries can and should be utilized for the FFS program (e.g., calculation of the percentage of dentists in the state who have billed Medicaid for services).
Availability of Primary Care Providers	*	x	States should be able to compute this measure for their PCCM programs. *It is not feasible to apply the measure specifications in the FFS environment. However, alternative methods of getting information on whether PCPs are available to Medicaid beneficiaries can and should be utilized for the FFS program (e.g., calculation of the percentage of primary care providers in the state who have billed Medicaid for designated services).
Availability of Mental Health/Chemical Dependency Providers	*	x	Some states have designated Mental Health/ Chemical Dependency Providers and should be able to compute this measure. Some states have carved out this program to a separate vendor, which should be able to compute this measure. *It is not feasible to apply the measure specifications in the FFS environment. However, alternative methods of getting information on whether MH/CD providers are available to Medicaid beneficiaries can and should be utilized for the FFS program (e.g., calculation of the percentage of MH/CD providers in the state who have billed Medicaid for designated services).

HEDIS Domain: Access to Care cont.

HEDIS Measure	*FFS*	*PCCM*	*Issues*
Availability of Obstetrical and Prenatal Care Providers	*	x	Some states have designated Obstetrical Care Case Managers and should be able to compute this measure. *It is not feasible to apply the measure specifications in the FFS environment. However, alternative methods of getting information on whether Obstetrical and Prenatal Care providers are available to Medicaid beneficiaries can and should be utilized for the FFS program (e.g., calculation of the percentage of Obstetrical and Prenatal Care providers in the state who have billed for designated services).
Initiation of Prenatal Care	x	x	Continuous enrollment: <279 days and > 43 days prior to delivery Similar to health plans, a state may find it difficult to identify live births. The HEDIS specifications suggest several methods that a state may wish to review. This measure requires complicated logic to identify prenatal visits.
Low Birth-Weight Deliveries at Facilities for High-Risk Deliveries and Neonates	x	x	Moratorium for reporting year 1997.
Annual Dental Visit	x	x	Continuous enrollment
Availability of Language Interpretation Services	x	x	This measure is applicable except for member services staff section of table. It is unlikely that a state has information on the languages spoken by the providers or their staff.

HEDIS Domain: Use of Services

HEDIS Measure	*FFS*	*PCCM*	*Issues*
Frequency of Ongoing Prenatal Care	x	x	Similar to health plans, a state may find it difficult to identify live births.
Well-Child Visits in the First 15 Months of Life	x	x	Continuous enrollment: from 31 days of age State will need to define primary care providers.
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	x	x	Continuous enrollment State will need to define primary care providers.
Adolescent Well-Care Visits	x	x	Continuous enrollment
Frequency of Selected Procedures	x	x	
Inpatient Utilization-General Hospital/Acute Care	x	x	
Ambulatory Care	x	x	
Inpatient Utilization - Nonacute Care	x	x	
Maternity Care -Discharge and Average Length of Stay	x	x	Similar to health plans, a state may find it difficult to identify live births. The HEDIS specifications suggest several methods that a state may wish to review.
C-Section Rate and VBAC rate	x	x	
Births and Average Length of Stay, Newborns	x	x	Identifying newborns separately from mothers.
Mental Health Utilization-Inpatient Discharges and Average Length of Stay	x	x	Are mental health services included in the regular FFS, PCCM and managed care programs, or delivered separately?
Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services	x	x	Are mental health services included in the regular FFS, PCCM and managed care programs, or delivered separately? Capturing a count of unique eligibles receiving services

HEDIS Domain: Use of Services, cont.

HEDIS Measure	*FFS*	*PCCM*	*Issues*
Chemical Dependency Utilization- Inpatient Discharges and Average Length of Stay	x	x	Are chemical dependency services included in the regular FFS, PCCM and managed care programs, or delivered separately?
Chemical Dependency Utilization- Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services	x	x	Are chemical dependency services included in the regular FFS, PCCM and managed care programs, or delivered separately? Capturing a count of unique eligibles receiving services.
Outpatient Drug Utilization	x	x	

HEDIS Domain: Cost of Care

HEDIS Measure	*FFS*	*PCCM*	*Issues*
Rate Trends	x	x	

V. SUMMARY OF METHODOLOGICAL ISSUES AND PROBLEM AREAS

Continuous enrollment requirement excludes significant parts of the relevant population

This issue is particularly pronounced where welfare reform has been instituted to make requalification for benefits an arduous (and frequent) process. In addition, this problem will likely continue to grow in the former Aid to Dependent Families and Children (AFDC) population, partly but not completely included in the Temporary Assistance for Needy Families (TANF) population created through welfare reform. The disabled and dually eligible population is more stable, but not suitable for comparison to AFDC or TANF beneficiaries. It is a care management problem and not a measurement problem that large numbers of Medicaid beneficiaries fail to meet HEDIS continuous enrollment requirements. The ability of a managed care organization to manage care and influence an enrollee's health or use of health services is affected by continuity of enrollment. If the Medicaid eligibility rules disrupt the continuity, they affect the MCO's ability to deliver *managed* care.

Measures with look-back periods that exceed the continuous enrollment period are difficult to capture

The primary challenge with respect to measures with look-back periods that exceed the continuous enrollment period is in obtaining complete data about services rendered prior to managed care enrollment or Medicaid eligibility for the FFS and PCCM programs. While the data problem is similar for the different programs, it is unknown whether the magnitude of the problem is also similar, or if it is greater in the FFS environment. A secondary concern regarding these measures is that they capture information not only about services provided, but also about care management. To the extent that a primary care provider or managed care organization captures information about the health status and needs of its population, it is able to manage care. It is not clear that a FFS program without a primary care provider or point of care management can claim the same level of responsibility, in spite of some states' view of the FFS program as the state's health plan.

Childhood Immunization Status and Adolescent Immunization Status

The Immunization Status measures capture two distinct aspects of performance. First, they measure service provided (i.e. number of immunizations given). Second, they capture performance related to management of care (through capture of information about services provided prior to enrollment - or to Medicaid eligibility). This second component of the measure is not easily measured in the FFS setting, as there is no accountable manager of care. While there is no comparable enrollment and responsibility by individual providers in the FFS system, many states view the FFS system as the state's health care plan. As such, the state assumes responsibility for the quality of care provided to its FFS population. Consequently, these measures can theoretically be applied to both the FFS and PCCM programs, although the data capture problems will be significant.

The measurement issues will be similar for managed care plans. For these measures, the greatest measurement problem is the availability of immunizations from sources other than the patient's doctor. In addition, the Childhood Immunization Status measure requires one year of continuous enrollment, but allows a look-back period of two years. The Adolescent Immunization Status measure requires one year of continuous enrollment, but a look-back period of up to nine years. For these reasons, the hybrid method is the most appropriate for collection of these two measures. As in the managed care setting, it may be difficult to obtain records from providers for services rendered prior to Medicaid eligibility, as non-Medicaid providers have no legal obligation to supply such records.

Cervical Cancer Screening

The Cervical Cancer Screening measure, like the Immunization Status measures, captures two distinct aspects of performance. First, it measures service provided (i.e. number of pap smears provided). Second, it captures performance related to management of care (through capture of information about services provided prior to enrollment - or to Medicaid eligibility). This second component of the measure is not easily measured in the FFS setting, as there is no accountable manager of care. While there is no comparable enrollment and responsibility by individual providers in the FFS system, many states view the FFS system as the state's health care plan. As such, the state assumes responsibility for the quality of care provided to its FFS population. Consequently, the measure can theoretically be applied to FFS, PCCM and managed care, although data capture problems will be significant.

Because the continuous enrollment period and look-back period for this measure differ, it is a very good candidate for the hybrid method. The challenge in this approach, aside from finding documentation of services that preceded Medicaid eligibility, will be to identify and locate the medical record documentation required for the measure, as a pap smear could be ordered by, and results reported to, any number of different providers. One method occasionally used by health plans to aid their medical record pursuit is to contact women for whom there was no administrative evidence of the service, ask them if they received the service and if so, from what provider. Once established, the state could then contact the appropriate provider for the medical record. As with the Immunization Status measures, there may be some logistical and legal hurdles to overcome in order to obtain medical records from non-Medicaid providers or from providers of services rendered prior to Medicaid eligibility. These issues are similar to those experienced by managed care plans, however, and should not affect the measure's comparability.

Data availability, reliability and validity are problematic

There are data issues in both the managed care and FFS settings. The specific data issues may vary by program and by state. Managed care plans typically have difficulty in capturing complete service-level information because they capitate providers or pay on other than a FFS basis. On the other hand, FFS programs may have the opposite problem, as providers have the incentive to submit claims for more services and more complex services than were actually performed. In addition, coding and record keeping practices are variable, even within small geographic areas, and providers who may feel underpaid for their clinical expertise are unlikely to invest heavily in

assuring the quality of their documentation and record keeping. NCQA has found, in auditing over 80 HMOs' HEDIS submissions, that there is wide variation in the quality of health plan reporting. In addition to the variability in provider-level claims submission, each state will have to assess its own MMIS for capture of appropriate information, and for the ability to integrate data and compute HEDIS measures as specified.

Global or package codes (OB)

Many states and managed care plans pay for obstetrical services using a single, global payment, which covers prenatal care, labor and delivery and postpartum care. When states or plans use this type of reimbursement method they often have difficulty obtaining the service level data needed (date of first prenatal care visit; number of prenatal care visits; date of postpartum visit; content of visits) to compute the relevant HEDIS statistics. This issue is common to both Medicaid FFS and managed care plans. Some plans and states have overcome this problem by requiring reporting of encounters or shadow claims, although compliance may be variable without any monetary incentive. The effect of this missing data problem is to require more costly medical record review to compute the HEDIS measures. Therefore, if a state does not receive FFS claims for obstetrical services, we recommend using the hybrid method to compute prenatal care in the first trimester, number of prenatal care visits and check ups after delivery. NCQA is currently working on a method to validate vital statistics data that might be used to compute some of these measures. At present, however, the literature suggests that birth certificates are not reliable sources of information about prenatal care.

Coding specificity

In addition to missing data due to global payments, states may undercount services when claims are not coded at the appropriate level of specificity. For example, a provider may bill for a well child visit in which immunizations are administered. However, because the antigen is available for free from other state agencies, the provider may not code the specific immunizations administered, and the claim will supply insufficient information to be able to count the immunizations given. In other situations, a HEDIS measure may require fifth digit ICD-9 coding, where only four digits are either routinely provided or captured in the MMIS system. Finally, some measures, such as Eye Exams for People with Diabetes, depend on diagnosis coding. Providers may omit any but the primary diagnosis or the diagnosis relevant to the immediate visit, or the MMIS may not capture diagnoses beyond those required to pay claims. In any of these circumstances, the state would have an incomplete data set. These issues are commonly found in managed care plans, as well. In order for HEDIS measures to reach their full potential for comparing HMOs and comparing HMO to FFS programs in Medicaid, states and plans must take steps to ensure the completeness and specificity of their data.

Completeness of data submitted by plans (for state calculation of measures)

Some states have asserted their intention to calculate HEDIS measures for their managed care plans, using encounter data submitted by plans. There are some potential pitfalls inherent in this approach. First, as described in some of the measure-specific discussion above, encounter data

are incomplete for some services. In particular, encounter data are incomplete for health care services provided prior to health plan membership (Childhood Immunization; Adolescent Immunization; Cervical Cancer Screening). Second, encounter data are likely to be incomplete for all of the same reasons as claims data, including the use of global payments and variable coding specificity by providers. HEDIS allows the use of medical records, as part of the hybrid method for calculating effectiveness of care measures, specifically because administrative data systems have, to date, proved inadequate for the calculation of these measures. Finally, there may be some political disadvantages to transferring the calculation of HEDIS measures from the health plans to the state. There is a tendency, when the numbers look unfavorable, to blame the measurement or calculation, rather than the underlying health plan quality, especially when the plan did not perform the calculations itself. If the HEDIS data are to be used for improvement, plans need to own the statistics as their own and as reflecting the reality of their health care delivery. This ownership may be easiest to secure if the plans perform their own computations.

Availability of comparable information on PCCM and FFS providers (residency completion; board certification; availability/openness of panel to new patients)

HEDIS contains a number of measures related to the provider network. The absence of the information needed to compute these measures is a severe problem in the FFS environment. Some of these measures may not be accessible to states, because they do not capture the data. While some states may have information about physician board certification and residency completion, others may not. And, even those states that do have such information may not have a complete count (or a comparable count to that obtained by HMOs) of the number of specialties in which a physician practices. Measures of the availability of providers and the openness of their practices to new Medicaid beneficiaries may also be problematic for states. Although a state could, potentially, identify the providers who are currently billing for services, it would be much more difficult to assess the number of providers who are accepting new beneficiaries (in the FFS program). The PCCM program, which must associate new Medicaid beneficiaries with providers, is more likely to maintain such information for primary care providers.

Comparability of Benefits Covered

As indicated above, when making comparisons of the performance of different delivery systems within a state or across states, analysts must evaluate the comparability of benefits covered under the different delivery systems and programs. Differences in the structure and methods of accessing a benefit must be considered as well. For example, if one Medicaid prescription drug program includes a closed formulary, another an open formulary, and a third no formulary at all there may be differences in the use of ambulatory or inpatient services that result from that benefit difference. Some prescription drug programs may cover tobacco cessation products, while others may not, again a difference which has implications for prescription drug use and may have implications for the use of other services. While it may not be possible to control for benefit differences, the analyst should understand what benefits are included for each of the programs being compared.

Changes in Program Structure and Enrollment Patterns Over Time

Under welfare reform and with increasing pressure on states to balance budgets, many states have made recent changes to their Medicaid programs. These changes include changes to eligibility rules, increasing the number of beneficiaries that must obtain care through managed care organizations, changing approaches to assigning beneficiaries to managed care organizations, etc. Each of these changes can affect performance on various HEDIS measures. Changes to eligibility rules, for example, could affect the proportion of Medicaid beneficiaries with long periods of Medicaid eligibility. This, in turn, could result in changes in continuity of care, as reflected in some of the preventive care measures and use of services measures. In order to understand changes in performance over time, the analyst needs to understand structural and programmatic changes that have occurred during the period under study.

Voluntary Managed Care Enrollment and Mandatory Enrollment

Some have theorized that Medicaid beneficiaries who voluntarily enroll in managed care organizations are more aware of the need for, and likely to seek, preventive care services than beneficiaries who are required to enroll in managed care. If such selection differences are real, there could be significant performance differences between managed care programs that are largely voluntary and those that are primarily mandatory. When comparing the performance of different Medicaid managed care systems, or of one managed care system over time, the analyst should assess differences in the enrollment requirements for the program.

Distribution of People with Third Party Coverage

The Work Group discussed the possibility that there may be differences in the proportion of Medicaid beneficiaries with dual coverage by delivery system. This might be especially true for the developmentally disabled population and for states that enroll Medicare beneficiaries in MCOs and for states with significant numbers of inhabitants in the Indian Health Service. If such differences exist, and beneficiaries in one delivery system have greater insurance coverage than beneficiaries in another delivery system, performance results could be biased.

VI. MEASUREMENT OPTIONS AND ISSUES

Measures to calculate using alternative data sources

Obstetric measures (Low Birthweight Babies, Low Birthweight Deliveries at Facilities for High Risk Deliveries and Neonates) and prenatal care measures (Prenatal Care in the First Trimester, Initiation of Prenatal Care, Frequency of Ongoing Prenatal Care) may be calculable using birth certificate data for both managed care plans and PCCM and FFS programs. Further study is needed to assess the validity and reliability of birth certificate data for these HEDIS measures.

Measures to calculate using alternative specifications

Before abandoning the HEDIS specifications because of the difficulties with the continuous enrollment criteria it may be valuable to reassess whether there are sufficient beneficiaries meeting the criteria to calculate a reliable statistic. If there are sufficient cases meeting the HEDIS eligibility requirements, the issue of large numbers of beneficiaries not represented in the measures becomes an analytic and communications problem. While the HEDIS® statistic may not be representative of the quality of care delivered to all Medicaid beneficiaries, these statistics reflect the best performance possible in the FFS and PCCM settings, as beneficiaries with shorter tenure are less likely to have received recommended services. This analytic framework may be sufficient, given the policy context for measuring performance of these programs is to assess the *relative* performance of managed care to justify its expansion, rather than to develop improvement strategies for the FFS or PCCM programs.

If, on the other hand, the number of beneficiaries drops off so dramatically that it is impossible to calculate a meaningful statistic, there may be value in recalculating some statistics using the per member per month approach used in Wisconsin. This approach makes it more difficult to assess the absolute performance of a plan/program, (in relation to a standard of care) but makes it easy to compare the relative level of service provision between plans and programs. The results will, for example, identify which plans or programs provide more or fewer services adjusted for population differences, but they will not identify which plans or programs are providing the recommended number of services.

The Work Group believes that it should be possible to apply most HEDIS measures, as specified, to PCCM and FFS delivery systems to support a variety of analyses relevant to Medicaid directors and policy makers. One advantage of using HEDIS in these other settings is that the measures have been field tested are valid and useful indicators of performance. A second advantage of applying HEDIS in these other settings is that Medicaid directors and policy makers can use the measures to compare performance across delivery systems, on a wide range of indicators. The Work Group is confident that HEDIS will prove useful in a variety of applications. Medicaid agencies and policy makers need to begin to experiment with collecting HEDIS data in PCCM and FFS settings and in analyzing performance over time and across delivery systems. As states gain experience and generate empirical evidence about the applicability of HEDIS measures in other settings, NCQA can build refinements into the next generation of HEDIS measures.

VII. FUTURE RESEARCH ISSUES

The Work Group identified a number of issues that were of considerable interest, for a "future research issues" list in order to focus the effort. These issues are briefly described below.

Measures of Health Status

The Work Group felt it would be valuable to obtain information about health status of Medicaid eligibles for comparison across delivery systems. Such measures could be used for risk adjustment purposes. A sound, science-based methodology for risk adjustment has yet to be developed. Once such methods are developed, research related to collection and validation of the required data will be required. Information on health status could also assist in evaluation of the effectiveness or outcomes of the different delivery systems.

FFS Servicing Providers Compared to Billing Providers

The Work Group identified an issue that impedes attribution of performance at the provider level in both the FFS system and some MCOs. Often, the provider that bills for a service is an institutional provider or group practice using one or a small number of Medicaid provider numbers. In such circumstances, it is not clear which individual provider actually rendered services to the patient. This confusion between servicing and billing providers makes it difficult to assess the performance of individual providers within the FFS system.

Selection Bias

Members of the Work Group expressed various concerns about the existence of and potential effects of selection bias in interpreting comparisons of the performance of different delivery systems. Where managed care enrollment is voluntary, there is a potential for selection bias. People who choose to enroll in a MCO may differ from those who choose to stay in the FFS program in ways that could affect the performance results reported by the different systems. The nature of enrollment must be considered as an analytical variable to be taken into account.

Voluntary Selection Compared to Default Assignment

This issue is a variant of the selection bias issue. In this case, regardless of whether managed care is mandatory or voluntary, Medicaid beneficiaries may actively choose a MCO or be assigned to a MCO according to an algorithm. Beneficiaries who actively choose a plan may differ from those who do not choose in ways that could affect the performance results reported by the different MCOs.

APPENDIX

SURVEY OF SELECTED STATES: APPROACHES TO COMPARING MANAGED CARE AND FEE-FOR SERVICE PERFORMANCE

Missouri

Missouri has developed a data system that links a variety of secondary data sources, including hospital discharge data and vital statistics birth record data, enabling the state to calculate a variety of measures of care in different settings and different payment systems. Because the managed care plans in Missouri are immature, their ability to calculate and report HEDIS measures is not fully developed. However, the state can calculate many similar measures using the secondary data sources mentioned. As examples, the state uses birth certificate information to calculate the number of prenatal care visits and the initiation of prenatal care, both for managed care plan enrollees and for the entire state population.

The state is using 1994 and 1995 FFS measurements as baseline year measures. In 1996, the state is calculating measures for both managed care and FFS, Medicaid and non-Medicaid. As of March 1997, 75% of the TANF population was enrolled in managed care, and 25% in FFS. Only limited comparisons had yet been made between managed care and FFS performance.

Oregon

As of March, 1997, 87% of beneficiaries (across all eligible groups) were enrolled in managed care plans, 7% in PCCM and 6-7% in FFS. Oregon has been using indicators derived from encounter data for the managed care program. While interested, the state has not begun to measure performance on the FFS side. In order to calculate performance measures using encounter data, the state has had to deviate from the HEDIS measurement specifications to some extent, due to missing data elements (such as outpatient procedure codes) and problems with the continuous enrollment requirements. (Because Oregon has a six-month enrollment cycle for Medicaid managed care, the plans are concerned about moving to a full-year continuous enrollment requirement). In addition, because of problems with data specificity (wide use of a universal provider code) the state cannot identify individual providers. On the FFS side, the state expects the data are more complete and accurate; there is no opportunity to use package codes or universal provider codes, and payments are tied to use of procedure codes.

New York

Three million New York Medicaid beneficiaries receive care through a number of different systems including HMO, PCCM, partial capitation and FFS. TANF beneficiaries constitute the majority of the managed care enrollment. The managed care program has a six-month lock-in, with recertification required every six months. Managed care contracts are maintained at the county level, so that changes in county contracts and movement of beneficiaries from one county to another results in high rates of disenrollment, despite the six-month lock-in.

New York has been working to calculate HEDIS measures for the FFS and PCCM programs, and collects HMO-reported data on both the Medicaid and commercial populations. The State has identified the following measurement challenges:

- Continuous enrollment requirements, both for the managed care and FFS populations, are difficult to meet. Many beneficiaries have short periods of enrollment, and are therefore excluded from the measures with a long continuous enrollment requirement.
- Some preventive care measures, including immunization status, are thought to reflect enrollment bias more than performance differences between the managed care and FFS systems. Because managed care enrollment has been voluntary for most beneficiaries, staff theorize that beneficiaries who choose managed care may be more aware of the need, and are motivated to seek, preventive care.
- The state uses vital statistics birth certificate data to calculate and risk adjust the birth weight and prenatal care measures for both the managed care and FFS populations. However, the vital statistics files are significantly delayed, preventing timely calculation of these measures.
- On the FFS side, while the state knows exactly which providers provide care to Medicaid beneficiaries, and could even identify which providers billed for services in the last year, it is not able to determine which providers are accepting *new* patients. As a result, the availability measures will be difficult to compute for the FFS system and will, at a minimum, require some estimation.
- Because the state pays for prenatal, labor and delivery and post partum care as part of a global fee, it is not able to determine whether a check up after delivery occurred. (This problem is one that many HMOs also encounter; the health plans use medical record review to overcome this missing administrative data.)

New York's Medicaid program maintains a formulary and pharmacy utilization review function for narcotics and various expensive medications. For these specified medications, the state knows both when a medication is prescribed and when it is dispensed, at least theoretically making it possible to compute the Beta Blocker measure. (The state was unsure whether the utilization review requirements applied to beta blockers.)

Indiana

Indiana's Medicaid beneficiaries are moving into managed care rapidly. They are towards the end of a three-year phase-in. Currently, approximately 60 percent of TANF beneficiaries are in managed care, and 40 percent are in a PCCM program. Additionally, persons with disabilities may enroll in managed care on a voluntary basis. The state has very strict welfare reform rules in effect, requiring welfare beneficiaries to requalify frequently. This frequent requalification process causes high turnover in the Medicaid program. Consequently, the state has great difficulty applying HEDIS continuous enrollment requirements. (As an example, there are approximately 40,000 beneficiaries aged two. Of these, only 1,300 were continuously enrolled for a full year, and of these, 706 had one DTP immunization.)

Because of the high turnover and short enrollment duration, the state has had to use QARI requirements (six months enrollment) to obtain meaningful measurement. In addition, data reported by the health plans are suspect. As a result, the Medicaid Department is using its external quality review organization (EQRO) to do focused studies to get information on childhood immunization, adolescent immunization, well child visits and prenatal care. The Department expects to have breast cancer and cervical cancer screening data from the plans by fall. In addition, the Department is trying to work with the Health Department to get vital statistics information for the birth and prenatal care measures. Currently very little information is available on the PCCM program, and there is limited funding available to collect more.

Iowa

Iowa is developing Medicaid managed care QA standards based on HEDIS 3.0. The whole system is designed to use FFS and PCCM programs as controls for the HMO program. Currently, the TANF population is enrolled in managed care and the PCCM program while the SSI and dually eligible beneficiaries receive care under the FFS system. In general, Iowa agreed with NCQA's proposed methodology, above, but had a few areas of difficulty:

- Continuos enrollment requirements are problematic. As an alternative, the state is looking at immunizations and EPSDT services for members enrolled for less than three months, 3-6 months, 6-9 months, 9-12 months and over 12 months.

- The state experienced data problems while calculating the prenatal care in the first trimester measure, due to global billing. The data may be available through vital statistics. Other problems with OB/GYN measures include the fact that much prenatal care is delivered by family practitioners. In addition, there are maternal health centers for high risk OB care.

- Availability of PCPs--The state can measure the availability of PCPs by counting the number of PCPs with contracts with Medicaid (PCCM) and by counting the number of PCPs with a Medicaid number (FFS). A single PCP could be counted in managed care, PCCM and FFS.